

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155741</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/03/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>FRIENDSHIP HEALTHCARE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2630 S KEYSTONE AVE</b> <b>INDIANAPOLIS, IN 46203</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and Investigation of Complaint IN00103094 completed on 2/17/12.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00106595.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00102099 completed on 1/19/12.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00105617 completed on 3/21/12.</p> <p>Complaint IN00103094 corrected.</p> <p>Survey dates: May 2 and 3, 2012</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team: Karina Gates, BHS TC Beth Walsh, RN Courtney Mujic, RN Barb Hughes, RN</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 2 Medicaid: 39</p>			{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	<p>Continued From page 1</p> <p>Other: 3 Total: 44</p> <p>Sample: 9</p> <p>Friendship Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and Complaint IN00103094.</p> <p>Quality review 5/07/12 by Suzanne Williams, RN</p>			{F 000}			